California Center for
Long Term Care Integration

Creating Better Systems of Care for People with Chronic Conditions: A Building Block Approach

Chronic Care Integration Planning Guide

July 2003

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Preface

The Center for Long Term Care Integration has developed the Chronic Care Integration Planning Guide to assist counties in developing their chronic care delivery systems. The guide dedicates one section each to the process for building a chronic care system (including chronic care values, overcoming internal hurdles, and the strategic and action planning process) as well as to each of seven building blocks of chronic care integration, including:

1) A comprehensive benefits package.
2) Delivery system capacity.
3) Care management mechanisms to integrate services at the point-of-service (the consumer).
4) System-wide governance/program administration.
5) Quality mechanisms that include performance measures and accountability for outcomes.
6) Financing and cost containment strategies.
7) Integrated information systems.

The idea of building blocks has been developing over time from many sources, but our most direct source has been through the Robert Wood Johnson Foundation's Medicare-Medicaid Integration Program and its excellent technical assistance papers.

Each section includes a worksheet and/or questions for counties to consider as they work towards accomplishing their chronic care system change goals and objectives. It is our hope that counties will find this information useful regardless of their stage in the planning and development process.

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Introduction
Creating Better Systems of Care for People with Chronic Conditions

What is the problem?
Fragmentation in the current long term care system not only fails to meet the needs of people with chronic health conditions, but also wastes money, time, and other precious resources. Our current medical care delivery system is trying to serve the needs of a chronic care population using an acute care approach. The long term care system tends to focus on social and supportive services, sometimes to the exclusion of medical care. These two systems need to be brought together into a consumer-focused continuum – a new chronic care system.

Complicating the effort to create a true chronic care system is the fact that the two major public payment sources, Medicare and Medicaid, are completely separate, with many contradictory provisions and requirements. Many people with chronic care needs have both Medicare and Medicaid coverage. The separate design of the two systems has created incentives for each to shift expenses to the other whenever possible. If a program cannot capture and control the utilization and expenditures related to both payment sources, then duplication, cost shifting, and lack of coordination are likely to continue.

There are substantial gaps in the availability of home and community based supportive services, which are paid for mostly by Medicaid. In order to fill these gaps, savings need to be effected elsewhere to pay for the new or enhanced services. It is believed that the most significant potential source of savings for dual eligibles is within Medicare services, particularly in the area of unnecessary or preventable hospitalization and emergency room use. If Medicare savings cannot be used to supplement services provided through Medicaid, then there is less of a chance to achieve integration's full potential impact. Only by bringing all services into a single system can savings in one sector be used to supplement care in another.

The increasing need for long term care services and the rising costs associated with this need are a growing concern for federal, state, and local policy makers. In most states, spending on long term care services constitutes over one-third of all Medicaid expenditures, with the majority of dollars used to fund nursing home care. Despite the preference of most consumers to receive care in their own home, most Medicaid payments for long term care go to nursing homes. Recognition of these problems has led to initiatives and demonstration projects aimed at better integrating chronic care services.

Goals of a chronic care system
The aim of integrating services for the chronically ill and disabled is to build effective, consumer-focused systems that organize acute and chronic care financing and service delivery into an easily accessible array of services and enable providers to deliver cost effective continuity of care to a defined target population.

The chronic care integration planning process

Planning for a new chronic care system is a long and difficult process. If the system is to be successful, many individuals and organizations will need to change how they behave and interact. Such a system cannot be imposed, but must be designed by those who will be involved. The counties that have received Long Term Care Integration Pilot Program (LTCIPP) grants from the California Department of Health Services, Office of Long Term Care have created processes for planning their integrated systems. An analysis of their efforts by the Center for Long Term Care Integration summarized the following non-sequential steps in the planning process:

1) Build community involvement, commitment, and awareness.
2) Develop a systematic understanding of the stakeholders and target population.
3) Convene groups and teams for completion of chronic care integration (CCI) tasks.
4) Develop a vision of chronic care integration.
5) Complete an inventory of existing services.
6) Conduct assessments of chronic care integration models.
7) Increase consumer education, awareness, and input.
8) Establish linkages with other providers- partner.
9) Design a chronic care integration program.
10) Begin coordination of services.

Key building blocks to address the problem

The development of an effective delivery system is a daunting task. One approach to system development is to identify key elements of the delivery system. Building on the work of the University of Maryland's Medicare/Medicaid Integration Project (1997) and Stone and Katz (1996), a preliminary list of these includes:

1) Determining what to include in a comprehensive benefits package.
2) Identifying the delivery system's capacity.
3) Creating care management mechanisms to integrate services at the point of service (the consumer).
4) Establishing a mechanism for system-wide governance/program administration.
5) Identifying quality mechanisms that include performance measures and accountability for outcomes.
6) Creating financing and cost containment strategies.
7) Developing integrated information systems.

How will these building blocks be used?

These elements offer a way to organize, prioritize, and evaluate program development. We propose them as an organizing structure for discussions on how to improve service delivery in California counties interested in building more effective delivery systems. We can use the building blocks to examine system development activities in interested California counties. This will help organize the information to identify and discuss innovations, best practices, challenges, roadblocks, and priority areas for technical assistance.

Process for Building a Chronic Care System

Organizations experienced in building new systems for people with chronic care needs have found that creating a values statement is an excellent way to bring diverse points of view into focus. Although they may disagree about how to make these values the foundation of the new program, they can agree on these broad philosophical statements. The values then serve to anchor people to a higher good when there are disagreements about implementation.

Chronic care integration values

Many of the LTCIPP counties developed value statements as part of their development of a vision for integration. The Communities Creating Long Term Care Options group (Options group) also affirmed a number of values as critical guiding principles for local integration efforts. The Options group included representatives from counties interested in learning more about how to proceed with chronic care improvements in their own communities as well as those who received AB-1040 planning and development grants. This diverse group included consumers, physicians, community-based organizations, health plans, county departments, and agencies responsible for services for the elderly and disabled, Area Agencies on Aging, and chronic care consultants working with counties.

The input from all of these groups resulted in these common values for developing a chronic care system. A chronic care system and the process used to develop it should include:

1) A comprehensive continuum of (a) home and community-based services (HCBS), (b) care delivered in residential and institutional settings, and (c) medical services (e.g., acute, primary, and ancillary).
2) Progress along the continuum from fragmentation, through improved coordination and partial integration, to full integration.
3) Services that are consumer-responsive and user-friendly.
4) Establishment of community standards for service delivery and quality assurance or quality improvement.
5) An emphasis on prevention of unnecessary illness and accidents, deterioration of chronic health conditions, and premature institutionalization.
6) Services that are delivered in a manner that is sensitive to clients' linguistic, religious, and cultural backgrounds as well as individual differences and preferences.
7) Appropriate types and amounts of care management for all who truly need it.
8) Cost neutrality after the startup phase.
9) Operations that balance standardization and efficiency with flexibility and personalization.
10) Ability to maintain people in the least restrictive appropriate environment.

11) Elimination of duplicative administrative, operational, and reporting requirements.

Creating change: overcoming internal hurdles and moving ahead
Change isn't easy for individuals and it's even harder for organizations and large systems. Chronic care integration requires that the existing players give up a certain degree of autonomy and also requires many to take on new and potentially risky financial commitments. To make this leap of faith, those with the power to make decisions must believe that ultimately the change will be for the better and that each organization will get a fair share of both the risk and the rewards. The process leading to such a decision is long and fraught with conflict and compromise. This section gathers some of the wisdom of counties and individuals who have successfully navigated the way to positive change.

Requirements for bringing about change.

- *Vision*- to motivate people/organizations to look beyond their individual interests; mutually developed and agreed upon by relevant stakeholders.
- *Planning*- to operationalize the vision and enable negotiation of compromises that will keep people involved over time
- *Competent people* involved at all stages of the process.
- *Incentives*- change will not occur unless there are incentives to do so.
- *Resources*- developing community-based systems requires infusion of resources. There are no free lunches—really!
- *Action plans*- how to move from a vision to action is the essence of the action plans.

Recommendations to create a momentum for change.

- Develop a compelling vision of the need for change. Enhance the message with:
    - Case studies/compelling vignettes.
    - Long term care experience of decision makers.
    - Pithy statistics and public service announcements.
- Educate decision makers about the value of chronic care options.
- Have a *realistic* promise of cost effectiveness.
    - Better allocation of funds rather than cost savings.
    - More efficient use of time/avoid duplication.
- Use key people.
    - Educate consumers to create pressure for change.
    - Identify/utilize champions.
    - Develop personal networks and contacts.

In chronic care integration development, counties face a number of internal challenges or hurdles. The following were identified by the Options group as impediments to reaching the action stage in their change process.

1) Lack of momentum.
2) Lack of direction.
3) Resistance to change.

Solutions.

Hurdle 1: Lack of momentum can be addressed by involving the right people, at the right time, and in the right ways.

- A high status "champion" to support and promote the cause.
- Active participation by upper-level management, key decision makers, and strategic thinkers who have bought in to the goals and the process. Asking for input can move people toward engagement and involvement.
- Consumer interest, demand, and support. Enlist consumers to turn up the volume.
- Strategic partnerships: Who is not involved who is necessary to move the process? Who could "monkey wrench" the process?
- Planning for small wins—use milestones and task force assignments/deliverables. It is important to have tangible evidence of progress to celebrate.

Hurdle 2: Lack of direction can be addressed by identifying the right model. This includes the following considerations:

- It is not necessary to re-invent the wheel. Look to existing models and select one that is appropriate. Creativity should be channeled into designing implementation strategies and building strategic partnerships.
- Build on services that already exist in the community and form strategic partnerships (e.g., Medi-Cal managed care).
- Ensure the approach is tangible and can be understood by the right people.
- Propose/work with the community to identify outcomes that are specific and realistic.
- Develop the accepted vision into agreed-upon action plans with targets, parties responsible, and required, periodic reports.

Hurdle 3: Resistance to change can be addressed by creating specific, concrete goals and realistic action plans.

- Use guiding principles and vision to resolve conflicts that arise and help move the process when it gets stuck.
- Agree to a consensus statement at each step and make it available to participants, including key decision makers.
- Recognize when to stop focusing on planning and start focusing on doing.
- Demonstrate success by capturing "low hanging fruit" and celebrating moderate victories to keep momentum going toward the vision.
- Develop a business plan.

Strategic and action planning process

Strategic planning is an organized process to determine what needs to be done and must include a method of verifying progress on goals and tasks.

Important considerations in strategic planning include:

1) Representation from all stakeholder groups. Get all perspectives by inviting broad representation from all interested groups.

2) Realistic goals for the available resources.
3) Milestones and schedule a "milestone meeting" to ensure that the group(s) is (are) making progress on the action plan.
4) Formal annual review to identify what was achieved.
5) Decision makers aware of the process and problems.
6) Balance between the need to keep people informed and maintaining tight time schedules.
7) Accountability for quantifiable, achievable results.
8) Subcommittees used, as appropriate, so people may contribute in areas they are interested in. Be sure the sub-committees have charters, defined goals, milestones and reporting periods.
9) Staffing sufficient to ensure progress.
10) Baseline data to track change over time.

Process decision points.

Planning for massive system change is an arduous and often costly endeavor that requires dedicated, enthusiastic leadership, as well as sustained commitment from stakeholders and decision-makers over a period of years (e.g. planning for Minnesota Senior Health Options took over six years). Decisions about who is involved in such a process, their powers and responsibilities, and the resources to be given to the program are crucial to its ultimate success. The following questions will help guide counties in their strategic and action planning process:

- What is the lead agency for planning chronic care options? *(Note: More than one agency or person can share leadership or other roles.)*
- Who is the primary person leading the effort, and to whom does he/she report? What are the person's decision-making responsibilities and limitations?
- How should the board of supervisors or governing body be involved?
- What health plans have been involved with or consulted during your planning process? If none, why not?
- What is the role of paid consultants in the planning process?
- How much time is dedicated to the planning of the chronic care system (by staff, consultants, etc)?
- What is the county steering group's role/job description?
- How many members are included? How are members chosen?
- What organizations and constituencies should be represented - health plans, hospitals, skilled nursing facilities (SNFs), community-based providers, government agencies, consumer groups, etc.
- What is the motivation for each constituent group or stakeholder to participate in the planning process? What will induce them to make the operational changes necessary to enable system change to happen?
- Who chairs the group? Does this person have good facilitation skills?
- Is there a regular meeting schedule?
- What subcommittees are required to do the more detailed and specialized work that will move the process along?

Performance criteria for the planning and development process.

- Commitment to change on the part of the board of supervisors or other existing governing board.
- Commitment of a leader (or leaders) willing and able to forcefully advocate change and support the process over a number of years.
- Funding for operations of the planning and development process: staff, consultants, equipment, supplies, etc.
- Involvement and, ultimately, buy-in from key stakeholders as needed to develop the political will to make meaningful system change.
- Clearly defined roles and responsibilities for the board of supervisors, the agency overseeing the planning effort, steering committee, subcommittees, and staff.
- Mission for the chronic care system and for the various elements of the system design process (steering committee, staff, subcommittees).
- A statement of the values that underlie the chronic care system design effort.
- Vision of the system end state after change is accomplished. Include how the system will perform for consumers, families, caregivers, providers, and payers.
- An action plan with specific assignments and accountability, milestones, and deadlines

Building Block #1: Comprehensive Array of Services

Chronic care systems need to be able to provide all the different kinds of services needed by the populations they serve. The first step is to identify the population to be included, and then determine what services will be needed to meet the needs of those people.

Target Population

Background.

In California, AB-1040 (1995) specifically authorizes inclusion of five groups:

1) Older adults.
2) Disabled adults under age 65.
3) People with mental disorders.
4) People with developmental disabilities.
5) Individuals with HIV or AIDS.

Within these groups, AB-1040 targets people who are dependent in two activities of daily living (ADLs) or are unable to remain at home without assistance.

Planning Questions.

- What populations will be included? Will the program use the AB-1040 definition or go beyond it?
- Will any of these groups (or any others) be carved out?
- How will you define "adult" (i.e., age 18+, age 21+)
- To what extent do these populations have similar or dissimilar service needs?
- Are the skills necessary to serve each population available?
- Is it politically feasible to include (or exclude) each of the groups?
- Is it financially feasible to capitate services to each of the groups under cost neutrality requirements?

Worksheet on target population.

Table 1 provides a worksheet for counties to use in determining their target population. It includes a list of conditions followed by levels of care.

Description of each column.

- *Ages*: Indicate if there are only specific age groups to be included.
- *Phase 1*, *Phase 2* and *Phase 3*: Check the appropriate column if being phased in. If known, provide dates for each phase in the header.
- *Never*: Check if this condition will never be included.
- *Mandatory/Voluntary*: Indicate if the group's enrollment will be mandatory (M) or voluntary (V).

Table 1: Worksheet on target population

	Ages	Phase 1	Phase 2	Phase 3	Never	Mandatory/ Voluntary
Condition/Level of Care/Intrinsic characteristics						
Aged						
Disabled						
Mentally retarded						
Chronically mentally ill						
HIV/AIDS						
ESRD (End-Stage Renal Disease)						
Children**						
Developmentally disabled						
Developmental center resident						
ICF/DD resident						
SNF or ICF resident						
Long term acute hospital patient						
Transitional inpatient care						
SNF certifiable						
At risk of SNF admission						
Subacute level						
Other:						
Other:						
Eligibility Status/Program Participation						
All Medi-cal eligibles						
Aged, bind, & disabled (ABD) Medi-cal eligibles						
SSI recipients						
Optional state supplement recipients						
Dual eligibles						
QMB						
SLMB						
MSSP participants						
Participants in other existing waiver programs						
IHSS recipients - PCS						
IHSS recipients - residual						
Categorically needy ABD with income at % of Federal Poverty Level						
Eligible as medically needy						
Eligible under spousal impoverishment rules						
Eligible for less than 3 mo.						
Retroactively eligible only						

	Ages	Phase 1	Phase 2	Phase 3	Never	Mandatory/ Voluntary
Eligible as foster children						
Non-Medi-Cal eligible (with other insurance/coverage): specify:						
Residing in SNF or ICF-DD						
Enrolled in Medi-Cal MCO						
Enrolled in Medicare MCO						
Other						
Other						
Other						
Other						

*** Describe fully anything you intend to do for children (under age 18)*

What geographic area will be included in the LTC program?

- Entire county
- Su-county area- describe:
- Multi-county (list of counties):

Services to be included in the chronic care system

Background.

People with chronic illnesses and disabilities often need a wide variety of services. They may need on-going medical treatment and monitoring, community services such as transportation, in-home assistance with personal care, meal preparation, and home maintenance. The current sources of funding for these services cross the boundaries of Medicaid, Medicare, and special age or disease/disability-related programs (such as Older Americans Act, AIDS programs, and mental health programs).

The history, professional orientation, and skill set involved in these different services are quite diverse. Managing a program that attempts to provide them all will be a very complex operation. Integrated chronic care systems will need to make decisions about whether to include all types of services or limit the scope to a particular set.

There is a distinction between Medicaid State Plan services and waiver services (non-state-plan services). If a program includes only state plan services, it may not be necessary to pursue a waiver, unless the rules under which the services are to be provided will be changed. Typical state plan services are physician care, pharmaceuticals, hospital care, home health, adult day health, and institutional care (SNF & ICF). If Medicaid dollars are to be used for services not included in the state plan, then a 1915(c) waiver is probably necessary. These services typically include case management, home modifications, extra amounts of state plan services, social model adult day care, etc.

In general, a comprehensive array of services includes primary, acute, and long term care (home and community-based, residential, institutional, behavioral health, and social service providers).

Questions.

- What services are needed by the included populations?
- Which services within primary, acute, and long term care become part of the integrated core?
- Which will be networked? Which will be provided by the plan directly?
- What is the relationship between Medi-Cal and Medicare-funded services?
- How will home and community-based services be included?
- How will changes to the system affect current clients and beneficiaries of programs to be included? How will phase-in plans minimize disruption to current users?

Steps to establish a comprehensive benefits package.

- Establish relationships with providers and get their input.
- Establish relationships with advocacy networks (aging, disability, DD, MH, AIDS, etc.).
- Review available services (LTC, acute, primary, ancillary, residential, transportation…).
- Review federal, state, and local programs that address the needs of the covered populations.
- Conduct a gap analysis.
- Get consumer input.
- Determine which services need to be added in order to have a comprehensive set of benefits.
- Determine whether waivers will be necessary to establish the planned continuum of services.

Worksheets on program services.

State plan services.

Table 2 lists the state plan services currently provided by Medi-Cal. The state plan includes certain amounts of each type of service. If the chronic care program wishes to provide more than the normal amounts, you will need to justify to the state how much extra service you wish to provide, to whom, under what circumstances, and also identify a source of funding or savings to provide the extra amounts. The California state plan is available on the CMS website at: http://www.cms.hhs.gov/medicaid/stateplans/toc.asp?state=CA. See particularly section 3.1 on amount, duration, and scope of services.

Description of each column.

- *Unaffected/ Coordinated*: Check if chronic care program will not affect funding & utilization of this service.
- *Capitated*: Check if service funding and utilization will be included in a capitated system.
- *Network/Contract/Plan*: Use "N" if the service will be provided by network providers, "C" if it will be an individually contracted service, or "P" if it will be provided by chronic care health plan staff.
- *Extended:* Check if service will be provided at a level that exceeds the

allowable by the Medi-Cal State Plan, thereby becoming an extended state plan service. (You will be required to identify a source of funding or savings to pay for these extended services).

- *Justify extended state plan service:* Describe changes to the normal state plan service (including how much extra, to whom, under what circumstances it will be provided beyond state plan levels; also source of funding or savings).

Table 2: State plan services

	Unaffected/ Coordinated	Capitated	Network/ Contract/ Plan	Extended	Justify extended state plan service
Acupuncture					
Acute care services: hospital inpatient, outpatient & emergency room services, and inpatient psychiatric					
Adult day health care (ADHC)					
Audiology					
Case management					
Chiropractor					
Clinic services					
Dental services					
Diagnostic services (lab, x-ray, etc.)					
Durable medical equipment					
EPSDT & pediatric services					
Hearing aids					
Hemodialysis (chronic)					
Home health agency services					
Hospice					
Hospital inpatient transitional care					
Hospital outpatient services and organized outpatient clinic services					
Intermediate care facility (ICF)					
ICF-DD - habilitative					
ICF-DD - nursing					
Local education agency (LEA) services					
Medical and surgical services furnished by a dentist					
Medical supplies, prescribed					
Medical transportation - emergency					
Medical transportation - non-emergency					
Non-physician medical practitioner (nurse practitioner, etc.)					
Occupational therapy					
Optometry services					
Other Medi-Cal covered outpatient services (e.g. heroin detox)					
Personal care services					

	Unaffected/ Coordinated	Capitated	Network/ Contract/ Plan	Extended	Justify extended state plan service
Pharmaceutical services					
Physical therapy					
Physician services					
Podiatry					
Pregnancy related services					
Prosthetic & orthotic devices related services					
Psychiatric & psychological services (limited)					
Rehabilitative mental health services					
Rural health clinic services (including FQHC)					
Sign language interpreter services					
Skilled nursing facility (SNF)					
Special tuberculosis related services					
Speech therapy services					
Subacute facility care					
Substance abuse treatment Services					
Transitional care nursing facility					

Table 3: Non-state plan services paid with Medi-Cal funding

	Pooled Funding	Capitate	Describe	Utilization Limits
Assistive devices				
Adult day care (Social)				
Case or care management (full continuum)				
Communication, translation, emergency response device				
Counseling				
Emergency housing				
Home maintenance & repairs				
Home modification				
Hospice				
Information & Assistance (I&R)				
Legal services				
Meal services				
Money management				
Nutrition counseling				
Personal care services				
Personal emergency response system				
Respite care				
Transportation or para transit				
Other				

Table 4: Other long term care programs (potential for capitation still unclear)

	Exclude	Coordinate	Pooled Funding	Capitate
Short-Doyle Mental Health				
Acute psychiatric				
Non-acute 24-hr. psychiatric health facility				
Medication support				
Day treatment & rehabilitation				
Residential treatment				
Crisis intervention				
Case management				
Crisis stabilization - ER & urgent care				
Population Specific				
AIDS case management program				
AIDS drug assistance program (ADAP)				
Miscellaneous Services				
Alzheimer's services				
Brain trauma projects				
Caregiver resource center (training)				
Residential care facility				

Non-Medi-Cal programs.

Some non-Medi-Cal programs and services for included populations can be integrated into a chronic care system with Medi-Cal, and others cannot. Chronic care planning groups need to think about each service and funding source and decide whether and how to include it in the system.

Table 5 lists non-Medi-Cal funded services that can be integrated with Medi-Cal services, with certain qualifications, such as voluntary enrollment.

Table 5: Other non-Medi-Cal funded services

	Coordinate	Capitate	Who will track funds & utilization?
IHSS – residual			
Medicare			
Other			

Table 6 lists non-Medi-Cal programs whose funding cannot be integrated with Medi-Cal because the economic and other qualifying criteria are different.

Table 6: Non-Medi-Cal programs (funding cannot be integrated with Medi-Cal)

	Exclude	Coordinate	Who will coordinate?
Older Americans Act (OAA)			
Veterans' administration services			
DHS public health services (non-Medi-Cal)			
Refugee health services			
Rural health services			
Contagious disease programs			
Immunization programs, etc.			
DSS services			
Adult protective services, Title 19 block grant			
Assistance dog special allowance			
Dept. of Rehabilitation Services			
California assistive technology system: I & R			
Client assistance program			
Deaf access assistance			
Elderly visually impaired			
Habilitation services			
Independent living centers (AB 204)			
Interpreter for hearing impaired			
Orientation center for the blind			
Rehabilitation counseling, training & placement			
Dept. of Developmental Disabilities			
Regional center services			
Developmental center			
Dept. of Mental Health Services			
County mental health services			
Mental health managed care services			
State psychiatric hospitals			
Traumatic brain injury project			
Dept. of Alcohol & Drug Programs			
Alcohol & substance abuse treatment			

Building Block #2: Delivery System Capacity

Delivery systems should reflect the target population, the source and extent of financing, and the scope of services to be included in the chronic care system. The new system will be built around many existing providers, who will have to be included in new provider networks unless many individual contracts are to be used.

Performance standards

Planners should raise these questions when developing system performance standards.

- How effective is the system at linking the benefit components so that the medical, mental health, social and supportive service, and housing needs of consumers are met in a way that the consumer perceives as seamless?
- Are providers in the network willing and able to care for people with chronic illnesses, including functional and cognitive impairments?
- Are delivery systems consumer focused?
- Does the delivery system assure/promote continuity of care?
- Are sufficient alternatives available to overcome the Medicaid nursing home bias?
- Are incentives to shift costs between funding sources removed?
- Are there effective integration mechanisms within the network and links to providers outside the network?
- How are services authorized and comprehensive care plans developed?

Service delivery network: current configuration

Counties should raise the following questions when assessing the current (and planned) configuration of their service delivery network.

- How integrated is the network of providers in the current service delivery system?
- Is the entire range of services represented within the system, including home and community-based, residential and social service providers?
- How are network services coordinated with those provided outside the network?
- Do any Medicaid managed care plans also participate in Medicare?
- Will you need incentives to entice people to keep Medicare in the plan?
- How many physicians in the Medi-Cal HMO network also accept Medicare?
- Does the state allow for the possibility that only Medicare risk contractors may bid on Medi-Cal MCO contracts?
- Is there any existing network of home and community based service providers, or will the managed chronic care plan need to contract with many individual providers?
- What services will be contracted out and which will be provided directly by the managed chronic care plan?
- Are providers located where the selected population is located?
- Is transportation available to enable disabled clients to reach providers?
- Do providers have experience with providing chronic care?

- Are there adequate specialists and providers of the types necessary to provide the full array of services to the chosen populations?

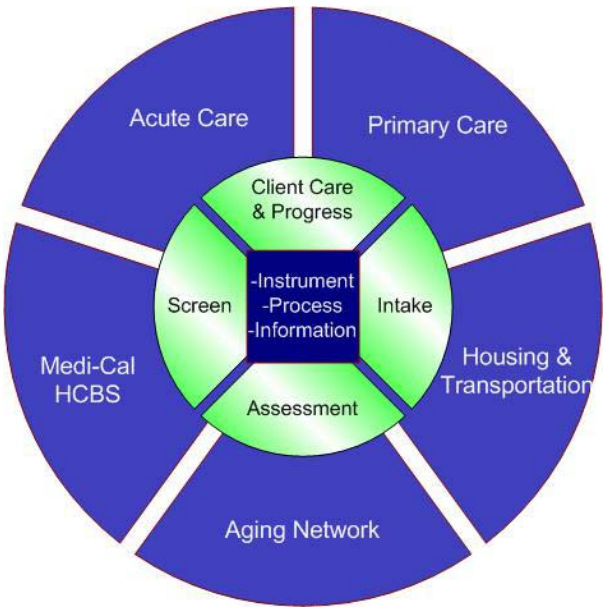
Service delivery network: planned configuration
Counties should raise the following questions when determining the future configuration of their service delivery network.

- How will connections be maintained with services for the population that are funded outside of the capitated rate (Older Americans Act, categorical funds, etc.)?
- How will relationships or contracts be established to provide non-traditional services that a dependent population may need in order to stay home (home modifications, extermination, home maintenance, etc.)?
- Where will (a) enrollment, (b) assessment, (c) service authorization, and (c) case management functions be located to ensure incentives are consonant with the program's goals?
- How will the various providers share risk?
- How will the chronic care system relate to assisted living or residential care facilities, HUD housing, and other congregate living arrangements for aged and disabled people?
- How will providers who serve special populations (such as religious and cultural groups) and providers who have a contractual obligation to participants or residents (such as continuing care retirement communities) be enabled to continue to serve their members?
- Which services will be integrated under a single contractor and which will be networked/coordinated with outside entities?

System design considerations and criteria
Figure 1 gives an overview of the chronic care system, showing that a core of information and client processes will connect the various types of services included in the system and network. To design such a system, a number of concepts need to be incorporated and decisions made about how the pieces will fit together.

- True chronic care approach - all service needs for the whole person are considered within a single system.
- Consumer-centered care that enables individuals to choose services, providers, and location of caregiving, and also enables them to accept a reasonable level of personal risk in order to maintain their desired lifestyle.
- Desirable, cost-effective alternatives to nursing home care.

Figure 1: System elements: network participants, functions, and information infrastructure



- Continuity of care as individual needs change.
- Enrollment counseling & member orientation.
- Consumers may keep their current providers (home care workers, especially) if at all possible.
- Internal complaint procedure complies with the Medi-Cal and Medicare appeals process.
- Program meets Medi-Cal and Medicare access standards for network adequacy, travel time, location, after hours care, monitoring and continuity of care.
- Program administration agency and providers have expertise/experience with aged, blind, and disabled Medi-Cal beneficiaries including subgroups such as those with dementia, HIV, AIDS, mental illness, and developmental disabilities.
- Special populations are addressed within the provider network or by separate networks.
- Coordination between network and non-network providers is addressed by communication protocols.
- Collaboration of key providers, networks, etc. is documented.
- Location of service authorization is identified.
- Location of enrollment and screening is identified.
- Agency/department that will pay for direct services is identified.
- Reimbursement of direct services to providers is clear.
- Documentation that clearly states how proposed changes will: 1) improve system efficiency; 2) improve service quality; 3) enhance consumer access; 4) maximize use of HCBS; 5) offer incentives to provide appropriate, high-quality care while maintaining cost neutrality; and 6) coordinate non-covered services and educate providers within and outside the program.

Building the network

Ideally, the chronic care system will have buy-in and participation from all of the major players in the chronic care system. Fighting fragmentation requires broad inclusivity. From the beginning, it is important to identify the vested interests of the various players and how the new system could be designed to serve clients and yet benefit providers & other stakeholders. Specifically, stakeholders that should be included throughout the planning process are:

- IHSS, including the public authority.
- MSSP.
- Aging network - at least the AAA, but also individual contractors.
- Mental health system agencies and providers.
- Community social services providers, such as the various religious family services agencies.
- All of the Medi-Cal long term care providers, including adult day health care (ADHC), SNF, ICF/ICF-DD, home health, and hospice providers.

- Residential care facilities, assisted living, HUD housing, continuing care retirement communities, and other age and population-relevant residential environments.
- Representatives of programs aimed at special demographic, religious, language, or cultural groups.
- Medical – physician practices, HMOs, and especially hospital discharge planners.
- Special population programs (AIDS, mental health, developmentally disabled, etc.).
- Consumer representatives.

Building Block #3:
Mechanisms to Integrate Care at the Point of Service (the Consumer)

Program design must include mechanisms for actual integration of care at the beneficiary level. Examples of mechanisms to integrate care include case management, interdisciplinary care teams, and centralized member records. Without these integration mechanisms, a program may do little more than recreate a fragmented array of services under an ineffective program umbrella.

Consumer access
The new system must have detailed plans for how screening and assessment will take place, how consumers will be informed of and be able to access needed services, and how consumer choice will be maximized.

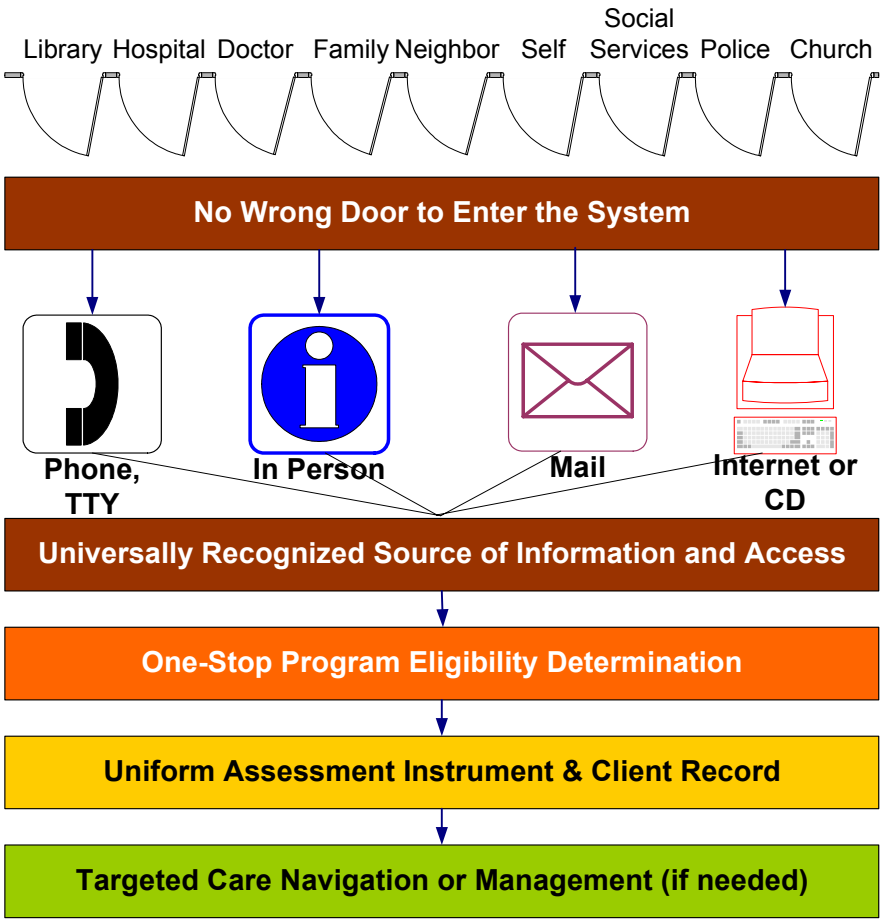
System design considerations and criteria
The following list includes aspects and criteria that counties should consider in their system design.

- Consumer access strategy.
- Screening criteria and process.
- Consumer education regarding enrollment, access, and choice.
- Assessment process.
- Referral system.
- Levels/services where consumer choice is available.
- Consumer involvement in care planning; inclusion of their needs and preferences.
- Care planning process for those with cognitive limitations.
- Accommodation of language, culture, religion, etc.

The guiding philosophy in a chronic care system is that consumers should be able to gain full access no matter how they approach the first contact. People often turn to friends, family, and their physician for information when they feel they need extra care. They also consult websites or go to the library. Many times the police, neighbors, or church members will notice a problem and decide to refer someone for assessment. Hospitals are also a common conduit for people who are recovering from illness, accident, or surgery; they see that a person couldn't make it on their own without help. The chronic care system must accommodate all of these potential entry points, which is called a "no wrong door" approach.

For full system efficiency, however, a chronic care system must have fully integrated, "one-stop" support once someone has approached for needed assistance. They should not have to go to multiple agencies for information, counseling, referrals, eligibility determination, assessment, or, if needed, care management. Figure 2 depicts this "no wrong door to the single point of entry" system.

Figure 2: Chronic care system access, screening, assessment, and targeted care management



Consumer-level system design guidelines

We discuss care management as the primary method for coordinating services at the consumer level. Care management, however, is not necessary for many consumers. Most people are capable of managing their own care and services. They may need advice and education, but once the determination of need and authorization of a service package has been completed, many, if not most, people can make it on their own. Research has shown that the most effective case management is usually that targeted at people who truly require an advocate. Our focus on care management assumes that it will be targeted at those who need it.

The focus of care management is on beneficiaries' individual service needs. Care management should begin with assessment of needs, performed by someone who is independent of financial incentives to offer care. The focus should be a holistic approach rather than discrete units of service or disciplines.

System planners should consider the following questions when determining how and where to coordinate services at the consumer level:

- What mechanisms will be used to link/integrate services?
- Is case management or some other mechanism used to integrate multi-disciplinary services?
- To what extent will there be common/shared assessments across disciplines, providers, and programs?
- Will a centralized consumer record exist?
- How will integration occur at the level of clinical practice?
- Where does accountability for clinical outcomes rest? Is the primary care physician or team leader accountable for clinical outcomes?
- Will Medicare and Medicaid services be integrated at the level of clinical practice?

Steps to design an effective care management program

- Identify where in the current system information and assistance (I & A), screening, intake, qualification, enrollment, and case management are being done.
- Identify the role of various disciplines in care management and care plan development in existing programs.
- Identify how consumers of different levels of cognitive ability are and/or could be involved in planning their own care.
- Trace how information follows consumers at present.
- Identify current efforts to coordinate programs across agencies, funding sources, client groups, etc.
- Identify the role of physicians in bringing chronic care into Medi-Cal (and Medicare) managed care organizations.
- Define the mechanisms that will prevent different providers and specialists from providing redundant or contradictory care, prescriptions, and treatments.
- Identify how the daily hands-on caregivers will provide input.
- Determine how all providers will be made aware of changes in a client's condition.
- Decide if there will be single or multiple care management agencies.

Performance criteria

These questions can help designers judge whether their program will meet standards for a true chronic care system.

- Are there mechanisms for comprehensive, objective assessment and access to appropriate services?
- Are participants assigned to a primary care physician or team leader for clinical services who is accountable for outcomes?
- Does the system have an interdisciplinary focus and are the participating disciplinary perspectives managed effectively to encourage synergy?
- Are there centralized consumer records that track health and functional status over time, service use, treatment, and providers involved?
- Are records accessible to all providers involved with care?

- Do records include appropriate safeguards to ensure confidentiality?
- How will the program appear seamless to the consumer? Does the consumer deal with only one system?
- Is it clear what agency will be responsible for oversight of the care management function?
- If assessment or care management will continue to reside in multiple agencies, how will the leadership role be determined?
- Is it clear who is accountable for case management when multiple providers are involved in care?
- Does case management cover the full range of services provided, from in-home supports to medical care?
- How will duplication of care management be minimized?
- How will gaps in the current care management function be filled?
- How will continuity across primary, acute, rehabilitative, and long term care be achieved?
- Is there a process for review of the adequacy and appropriateness of care plans?
- How will transitions in level and location of care be facilitated?
- Care manager authority – to what degree will the case manager authorize services (as opposed to recommending or coordinating only)
- Are there mechanisms for coordinating care by non-network providers and services that are not included in the program? What are these mechanisms?
- How does the system accommodate different levels of need for care navigation, advocacy, and on-going management, from no need at all to total need?
- How is consumer direction incorporated at all levels and types of care?

Building Block #4: System-wide Governance and Program Administration

Each county engaged in planning for a publicly funded chronic care system faces difficult decisions involving substantial amounts of power and money. The initial decisions about who will control the integrated fund may be contentious. The role of different organizations in the system will be subject to negotiation.

The previous chapter dealt with decisions that all chronic care systems will have to face. This chapter begins one of the major areas where different models will lead to vastly different organizational structures. Still, there will be commonalities.

Lead organization

All systems need to decide which organization will take the lead. If only the long term care services are to be included, it is likely that administration will reside in a public or private social services type agency. If the full continuum of medical, social, and supportive services are included in a pooled funding stream, it is more likely that a health plan will take the lead, particularly if it is to be a capitated system. If a non-governmental organization becomes the lead agency, it will be important to establish mechanisms by which the county retains a degree of authority, at least in the realms of quality control and consumer grievances. It may also be a good idea to have different organizations proposing and approving changes, or performing functions and overseeing and evaluating those functions. The inclusion of a powerful governing board can also take care of this need for oversight.

Determining the lead organization: desired qualifications

- Expertise of staff.
- Experience with aged, blind, and disabled populations.
- Cultural competence.
- Medical and social model expertise/experience.
- Respect of other participants.
- Positive reputation with consumers.
- Business structure capable of supporting the financial requirements.
- Good relationships with board of supervisors, advisory committees, and local agencies.
- Staff should have capacity, experience and demonstrated ability to[1]:
    - Manage services.
    - Deal with financial risk.
    - Maximize federal, state, and private funding and waivers.
    - Maximize revenue (discretionary funds).
    - Leverage political influence.

Governance structure

Governance refers to the structure for oversight of the integrated program. This function can reside in the same agency that administers the program or it can be an independent body.

[1] 8/31/00 Governance Ad-Hoc Committee, Contra Costa County.

Governance agency options.

Governance agency options include the following:[2]

- Public authority.
  - Board of supervisors as governing body.
  - Separate governing body appointed by board of supervisors.
- County department.
  - Existing department.
  - New department of chronic care integration.
  - Joint effort of existing departments.
- Non-profit organization.
- Public/private joint ventures agreement.

Effective boards.

The following lists includes basic responsibilities of non-profit boards:[3]

- Determine the organization's mission and purpose.
- Ensure effective organizational planning.
- Determine, monitor, and strengthen the organization's programs and services.
- Ensure adequate resources.
- Ensure resources are managed effectively
- Enhance the organization's public standing.
- Ensure legal and ethical integrity and maintain accountability.
- Recruit and orient new board members and assess board performance
- Select the chief executive.
- Support the chief executive and assess his or her performance.

Administrative structure planning

The following questions will assist counties in determining the criteria for system-wide administration:

- Has a governance structure been identified?
- What kind of governing board will be established? Who will be represented?
- How will consumers be involved in the system?
- What are the various proposed structures for administering LTCI?
- What models in California might be useful to build on for program administration (i.e. Medi-Cal managed care, PACE, and SCAN SHMO)?
- What approaches were used locally to develop Medi-Cal managed care? Can this structure serve as a base for the chronic care system?
- What is the enrollment process? Will this function be separate from service authorization and provision?
- How will contracts be administered?
- What is the current data reporting process for each agency and service?
- Where are data currently collected and analyzed?
- Is there unified enrollment, disenrollment, data collection, payment systems, etc. for Medicare and Medi-Cal?

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[2] (8/31/00). *Governance AdHoc Committee*, Contra Costa County.

[3] (2002). *Ten Basic Responsibilities of Nonprofit Boards*. Washington, DC: BoardSource.

- How will the program relate to Medi-Cal managed care plans, other local managed care plans, including Medicare managed care organizations, and services not included in the system?
- Has contract oversight of Medicare and Medi-Cal been unified or do providers contract with different entities?
- To what extent are operating systems integrated (e.g. have Medicaid and Medicare enrollment processes been combined into one?)?

System design considerations and criteria.

Before proceeding with designing system-wide governance and program administration, planners need to understand the current systems. For example:

- System inefficiencies- where are they? Is there duplication?
- What is the perceived level of need for integration in the community?
- Potential conflicts of interest between screening, assessment, enrollment authorization, service authorization, and care management. Who handles each of these functions now? What would happen if these were to be centralized? How should the functions be allocated across agencies or programs in the new system?
- Current relationship of Medi-Cal and Medicare in existing programs.
- Current Medi-Cal and Medicare managed care organization- are they involved? Are there any managed care organizations that serve both populations?
- Current contracts- what are they, what are their terms, how can they be integrated into the new system?
- Organizational structure that clearly shows the relationships among all participating groups and providers.
    - Relationship to the planning/design steering committee and subcommittees.
    - Relationship to board of supervisors.
    - Relationship to administrative agency, health plans, providers, etc.
    - Consumer involvement.

Advisory committees

Whenever public dollars are to be expended, a mechanism for stakeholder involvement and influence is always required.

The following questions should help in determining the responsibilities and role of the advisory committee.

- What is the role of the committee in decision-making?
- Does the advisory committee have any real power to influence decisions?
- What is the relationship of the advisory committee to the board of supervisors, local organizing group, steering committee, administrative agency, and other relevant agencies?

The advisory committee should include:

- Chronic care consumers.

- Advocacy groups.
- Representatives of employees who deliver direct care.
- Representatives of long term care providers.
- Representatives of the medical community: physicians, hospitals, and health plans,
- Members of planning and development steering committee and subcommittees.

Worksheet on reducing duplication

A major goal of chronic care integration is to reduce fragmentation and duplication. Table 7 lists the functions that could be redistributed in the new system and some of the possibilities for their ultimate location.

Table 7: Functions that will be redistributed

Program	Currently done by:	Moved to:	Integrated Into:	Function to be combined with:
I & A or I & R				
Screening/Intake				
Eligibility determination				
Enrollment				
Assessment				
Service authorization				
Case management				
IHSS				
MSSP				
Other waivers				

Building Block #5: Quality Mechanisms that Include Performance Measures and Accountability for Outcomes

The aim of a quality program is to continuously improve services and operations to achieve better outcomes and greater efficiency. All publicly-funded programs require participants to measure and document quality. Quality programs serve three general purposes: 1) quality improvement, 2) accountability, and 3) research. Quality measures can be based on structure, process, or outcomes. Structural measures look at the presence or absence of certain systems, equipment, processes, etc. Process measures look at what providers do. In contrast, outcomes look at the effectiveness of what providers do. Generally, structure and processes are easier to measure and outcomes are more meaningful.

Each player must have a quality assurance (QA) system that measures outcomes to ensure that agreed-upon services are provided as planned and integrate with the overall system. The QA system must also ensure that data are reported in a timely fashion.

Overarching quality systems and design considerations
A single point of accountability should be established for the chronic care system, but for practical reasons it may be necessary to do this at each level of program design and operation (i.e. patient level, provider level, health plan level, county level, state level). Quality requirements for Medicare, Medi-Cal, IHSS, MSSP, and all integrated programs should be unified.

The quality improvement system needs to be incorporated from day one. Selected measures must be planned into operations and information systems. Planners should seek existing studies and plan the new accountability and quality assurance procedures using these questions as a starting point:

- Have there been any baseline studies of service or system effectiveness?
- Have there been any consumer satisfaction surveys? If so, review for relevance and completeness; if not, consider measuring the current state as a baseline for future improvement.
- What are the lessons learned from other similar efforts? Conduct literature search on standards for long term care/chronic care.
- How will quality standards be established? Who will be involved in the process?
- Who will oversee the quality assurance and accountability plan?
- Has a single entity been identified as accountable for beneficiary outcomes, or do quality efforts focus on the individual services offered by the various providers within the system?
- How does the quality assurance process relate to providers and participants throughout the system? Specify roles and responsibilities of each player.
- Is there staff buy-in? It will take a concerted effort by staff, so they must understand the need and be trained in how to record such information properly.

- Have Medicaid and Medicare quality requirements been integrated into a single set?
- How will utilization review and management be incorporated into the new system?
- Are information systems in place that will allow capture of evaluative data? If so, are they adequate? If not, work to design and implement appropriate systems.

Areas for QA efforts

- Provider access standards (time between contact and appointment, geographic coverage, language skills of providers, translation services, etc.).
- Grievance response standards.
- Clinical standards (treatment protocols, average outcomes, etc.).
- Financial/cost-neutrality standards (use of formulary, etc.).
- Consumer satisfaction.
- Provider satisfaction.
- Reduction of fragmentation and duplication.

Quality management approaches in selected programs

Table 8 shows the quality management approaches in four programs: 1) Arizona Long Term Care System; 2) Minnesota Senior Health Options; 3) PACE; and 4) Texas STAR+Plus. For each program, the following items are highlighted: quality management philosophy; participation in quality management; internal QA standards; performance measures; and quality oversight.

This table shows that there are roles for CMS, the state, the lead/administrative agency, the health plan, and individual providers. Each level will have requirements of the next lower level as well as data collection and analysis responsibilities.

Table 8: Quality management in selected programs (Source: MMIP Technical Assistance Paper #1)

	QM Philosophy	Participation in QM	Internal QA Standards	Performance Measures	Quality Oversight
AZ Long Term Care System	Leave most QM decisions to health plans.	***State***: quarterly meetings with plan Medical Directors, Quality Managers and Care Managers ***MCO***: no specific requirements for provider participation in QM process.	Standards coordinated with State's managed care system for acute care; limited coordination with Medicare.	Development of process/ outcome measures which cross settings of care.	Separate reviews conducted by same PRO for external quality review. Onsite state reviews conducted independent of other agencies and managed care programs.
MN Senior Health Options	QM is a negotiated process between MCO and service provider; ***MCO*** focus on "transitions" between services and settings.	***State***: Ad-hoc involvement on issue-specific basis. ***MCO***: inclusion of service providers and settings in QM process	Plans subject to blended set of M'care/M'caid standards where feasible; efforts to increase consistency among standards of state oversight agencies.	Development of clinical and structural measures which cross settings of care in area of diabetes, incontinence, and care transitions.	CMS oversight of state conducted under Merged Review Guide; external quality reviews of plans conducted by same PRO for M'care/M'caid.
PACE *	Prescribed framework for QM at PACE provider level; focus on process and outcome of care.	***Site***: QM process includes active participation from all areas of PACE program, including participants and caregivers.	Separate standards not necessarily coordinated with state/federal standards.	Development of outcome measures now underway focusing on functional and medical conditions.	Independent review for PACE accreditation unrelated to M'caid and M'care external quality reviews.
Texas Star+Plus	Overall structure of QM follows QARI guidelines; flexibility built into system allowing for plan variations.	***State***: state-sponsored advisory committee includes broad range of input. ***Plan***: QI Committee includes older persons and persons with disabilities and community providers.	Standards compatible with those of TANF program where applicable; additional standards modeled after Contracting Specifications for dually eligible. **	State uses subset of HEDIS 3.0; considering applying QI indicators for nursing facilities developed under the State's case-mix demonstration project to track medical and functional outcomes of NF members.	State currently soliciting proposals for M'caid external review from PROs, PRO-like entities and accrediting bodies; no final decision as to whether M'care PRO will be selected.

* Responses reflect standards included in draft PACE accreditation standards. These standards are subject to future revision.

** CMS's Medicaid Managed Care Technical Advisory Group (with assistance from The Center for Vulnerable Populations (Collaboration of The National Academy for State Health Policy and The Institute for Health Policy - Brandeis University), A Framework for the Development of Managed Care Contracting Specifications for Dually Eligible Adults, November 1996.

QARI: Quality Assurance Reform Initiative
PRO: Professional Review Organization
QI: Quality Improvement
HEDIS: Health Plan Employer Information and Data Set

Building Block #6: Financing and Cost Containment Strategies

Goals

The parameters of the system's financing and rate structure should derive from the program's basic goals and priorities. These goals, which may conflict or have multiple implementation schedules, influence what services will remain fee-for-service, the scope and structure of a capitation rate, how much risk to pass on or share, and whether the program will be voluntary or mandatory. One of the most convincing reasons for integrating Medicare and Medicaid is that financial incentives created by the program will be aligned to eliminate cost shifting. Other common goals for a chronic care system are to:

- Eliminate fragmented service delivery.
- Contain costs.
- Develop a coordinated service delivery system.
- Improve quality of services provided.
- Develop community-based managed care infrastructures.
- Provide flexibility in benefit design.
- Maximize consumer choice.

Protection from extreme risk

No matter how the new system is designed, the county or health plan will have to be protected from extreme expenses, particularly in the beginning phases when there hasn't been enough time to develop a sense of average, nor a pool of funds to draw on for such contingencies.

Risk Sharing: The purpose of risk sharing is 1) to allow new risk-based programs time to develop and refine service delivery systems before assuming full financial risk, and 2) to cushion fluctuations between actual costs and capitation rates while maintaining a strong incentive for cost control. Risk sharing usually involves a contract between the state and the health plan or administrative agency whereby there is a graduated percentage sharing of risk above certain dollar levels. For example, if 95% of beneficiaries have expenditures under $40,000, then the state and the program could share the risk 75:25% from $40,000 to $50,000 50:50% up to $60,000 and 75:25% for people who spend over $70,000 annually. Some states require a similar plan for "profit" sharing at the other end of the risk spectrum.

Reinsurance: Reinsurance involves buying insurance, based on either aggregate or individual expenses, as a protection against catastrophic claims that could potentially jeopardize a program. Aggregate coverage protects the entity against unexpectedly high utilization by all clients. Individual coverage protects the entity from unexpectedly high utilization by any individual enrollee[4].

Risk corridors: risk sharing strategies for transitioning health providers/entities toward

[4] The terms reinsurance and stop-loss coverage are sometimes used interchangeably, however, reinsurance generally applies to managed care organizations and medical carve out programs such as mental health and prescription drugs, while stop-loss coverage is associated with physicians and providers.)

assuming full capitation risk on a gradual basis; obtained through insurance separate from the state. The risk is shared between the entity and the reinsurer (payer) and is determined annually.

Stair step: multiple layers (corridors) of risk to reduce the cost of insurance. For example, 1st level of risk might be set at 25%, 2nd at 50%, 3rd at 100%. If the amount goes beyond the agreed-upon amount for the 1st level, then the risk would be shared 75% (county)/25% (reinsurer); 2nd level 50/50; and 3rd level and above 100% reinsurer.

Cliff drop: one layer of risk: more expensive. The insurance is responsible for 100% of anything over the agreed-upon amount.

Risk pool: gains are deposited to a pool and retained by the plan to fund losses in subsequent years or to facilitate the program's assumption of full risk. This could be done within a single plan or multiple plans could collaborate to share a risk pool.

Steps for developing financing and cost containment strategies

- Understand current expenditure patterns – how much, on whom, for what, etc.
- Understand sources of funding- federal, state, county, local, Medicare, Medi-Cal, Older Americans Act Title III, etc.
- Analyze the financial incentives built into each program and how these affect the delivery of service. Plan a system that aligns incentives with appropriate processes of care.
- Estimate the impact of system changes on utilization and expenditures for the included populations.
- Perform an actuarial analysis of current expenditures and project to the future using a variety of assumptions regarding populations, utilization, and reimbursement rates.
- Work with the state (Medi-Cal managed care rate division) on capitation rate.
- Understand outliers and associated characteristics.
- Devise plan for risk sharing, risk corridors, reinsurance, etc. to safeguard county/health plan from extremes.
- Work out budget for each phase-in stage. Common phase-in stages are managed fee-for-service and partial capitation.
- Accommodate federal and state fiscal and auditing requirements, as needed
- Identify who will administer the consolidated program fund (most likely a government agency or not-for-profit).
- Assign accountability for the fund to ensure Medi-Cal (and Medicare) dollars are expended in a way consistent with federal and state requirements.

Cost neutrality determination

- Which funding mechanism best describes this LTC program?
  - ❑ Existing funding: Coordination facilitated by administrative adjustments or strategies such as a common assessment tool or single point of entry.
  - ❑ Case management funded from existing resources (e.g. redirected county Target Case Management and/or county Medi-Cal Administrative Activities funds).
  - ❑ Case management funded from an outside funding source (e.g. grant funds).
  - ❑ Case management funded by Medi-Cal through an HCBS waiver.
- In what way will your LTC program calculate cost neutrality (choose one):
  - ❑ Per eligible person; OR
  - ❑ By population.
- Which, if any, capitation approach do you plan to adopt:
  - ❑ Managed fee-for-service.
  - ❑ Capitation of some Medi-Cal funds. Please list:
  - ❑ Capitation of all Medi-Cal funds.
  - ❑ Capitation of all Medi-Cal funds with integration of some additional funding streams. List the other funding streams:
  - ❑ Full integration: capitation of all Medi-Cal, IHSS and Medicare funding.
  - ❑ Other. Please specify:
- What is the estimated monthly additional cost of extended state plan services? $
- What is the estimated monthly additional cost of non-state-plan services to be paid for by Medi-Cal: $
- How will you assure comparable savings in other services (for the services you intend to add and/or the extended services to be funded by Medi-Cal, as noted above)?
- What specific services do you expect to be able to generate savings from?
- How will you create the savings? Describe:
- What is the research/resource information that the estimates are based on? Describe:

Cost neutrality worksheet.

Table 9 provides a worksheet for counties to use in determining the financial structure of their chronic care program.

Table 9: Cost neutrality worksheet

Non-State-Plan or Extended State Plan Service to be added	Source of savings	How will savings be effected	Source of information re: potential savings	Approx. $ per mo. savings

Building Block #7: Integrated Information Systems

One of the major building blocks for chronic care integration is the development of integrated information systems (IIS). An effective IIS integrates clinical, administrative, and financial operations, linking key players in an individual's care at all organizational levels (e.g., case manager, providers, policymakers, etc.) to improve care for consumers and for the system as a whole. The integration of information builds on QA efforts to develop common data elements and measures. It requires the integration of program data across programs that can be shared across providers.

Moving to an integrated information system (IIS) – planning questions

- Which agencies, programs, and providers will need to collect and use program data?
- Are their existing data and computer systems compatible?
- Is there a uniform assessment process?
- Are there uniform data elements?
- If multiple types of assessment are used, are there mechanisms to integrate (i.e., link) the information?

Service and provider information base for consumer access

Consumers should have access to information needed to participate in decision-making processes related to their care (to the extent that they wish to do so). At a minimum, a centralized repository for information describing the providers and services that are located in the consumer's local area should be made available to the public. Criteria for a centralized repository of information include:

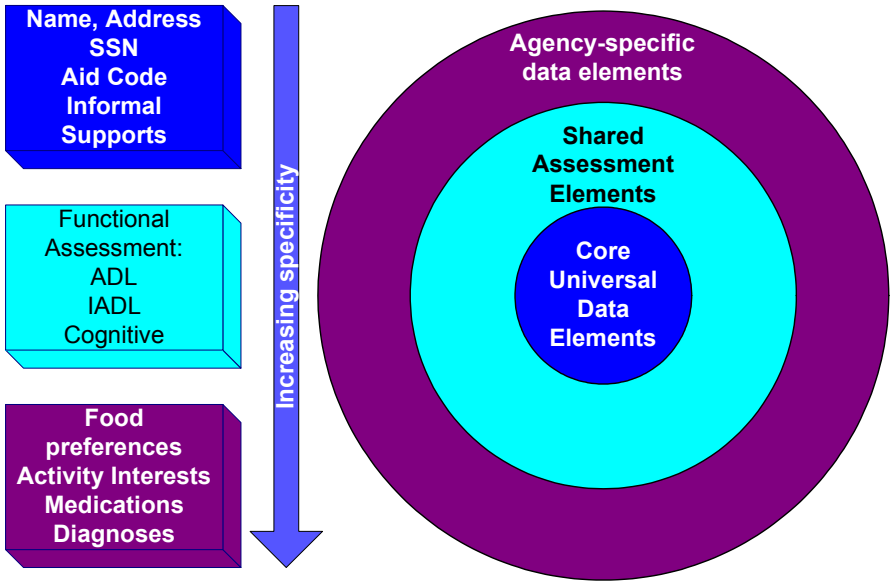
- There must be a process for providers listed in the database to correct, update, and otherwise have input into the form and content of what is presented about them.
- Information on providers and services must be kept up to date.
- Information should be presented in multiple ways to reach all potential audiences. Systems, ideally, should be web-based, but also accessible by telephone and through specialized equipment for various disabilities. Additionally, provider information should be available as a directory or resource guide that can be placed in libraries, senior centers, doctors' offices, and can be easily used by people who do not have computers or special equipment.
- Information must be translated into languages used by the target audience, including Braille.
- Active promotion must be used to ensure that all stakeholders are aware of the service and are encouraged to use it. Promotion must include media in local neighborhoods and in the same languages as are used in the database translations.

Client-level information base

The second level of a centralized information source is a client-level database that enables shared access across providers to intake and assessment information, care plans, key health data, and service utilization information. If true coordination is to happen, such that the client does not experience duplication and fragmentation, then providers and care managers will need to have access to relevant client data. Each provider participating in a shared client-level information system would need to agree to the data elements included in the client record.

Most plans for a client-level information system have multiple levels of security and specificity. Figure 3 shows that each record would have core data elements that every user would need. These include such things as the client's name and address, eligibility information, and information about the person to contact in case of emergency. The second level of information would include functional assessment results and other information that would be useful to most providers. At the third level would be the most sensitive information as well as the most specific. Medical information such as diagnoses and medications would go here. At this level would also be more agency-specific information such as food preferences for meal programs and activity interests for day care programs. Each level would have appropriate security features to enable only those who need the information to gain access to it.

Fig. 3: Client-level information



Design criteria for client-level information system.

- Agreement from participants on core data elements to include in a uniform assessment tool or agreement on an "off the shelf" system.
- A hierarchical or nested approach to data elements – going from identification information (client name, address, etc.), to general information about

condition (ADLs, cognitive status, social supports, etc.), to program-specific information (such as food preferences for a meal plan).
- Multiple-level access provisions assigned on a "need-to-know" basis.
- HIPAA-compliant privacy protections (CMS Main HIPAA page: http://www.cms.gov/hipaa/hipaa2/default.asp).
- Redundancy and backup so that access is virtually guaranteed.
- Compatibility with handheld systems (optional, but more and more providers are using such systems to enter data at the "bedside").
- Decentralized data upload.
- Compatibility with "smart card" technology that can be encoded on a credit-card type of medium that can be carried to ensure that important information is available to non-network providers in an emergency.

In order to make the phase-in of such a system as painless as possible, it is important to design familiar views/forms for each participant that automatically display information from other sources in the relevant data fields (with reference to the original source). In other words, if another provider has already entered information called for in an agency's assessment form, it will be entered automatically and show where the information came from. The agency would then have the choice of accepting that information or deleting it (if they have that level of security access) and entering their own. For example, any information used in both IHSS and MSSP assessment forms would automatically show up formatted according to the requirements of each program. This is a fairly typical database function.

This concept is in the infancy stages presently. The hardware, software, and agreements/protocols necessary to implement this system will require substantial investments from participants and from state and county government.

Uniform assessment

Part of the problem of fragmentation is the burden of multiple assessments and reporting requirements. Uniform assessment facilitates client tracking over time and uses the same instrument no matter where someone enters the system. Even if the payment and/or service delivery systems are not completely integrated, uniform assessment will be of value.

One example of a uniform assessment instrument is the Minimum Data Set for Home Care (MDS-HC). The MDS-HC is a comprehensive instrument, designed for care planning, that collects information on clinical, functional, and social characteristics of the client. The information that is collected serves as the basis of algorithms or "triggers" that can be used to identify potential problems that might be addressed by care planning. The associated client assessment protocols (CAPs) assist the care planner in thinking through the design of an appropriate care plan. For every condition identified, a "treatment" suggestion will be inserted automatically into the care plan and can then be changed, accepted as is, or deleted. The data can also be used for administrative purposes (i.e., policy and planning), tracking outcomes, and quality assurance. Quality indicators have been developed for the MDS-HC. While it would be possible to apply the

technology of the triggers and CAPs without an automated system, the process of hand-calculating the triggers would be so burdensome to the case manager as to be ineffective for most client populations.

Worksheet on integrated information systems
General questions to consider in approaching the design of an IIS:

- Do you intend to use a uniform assessment tool?
  - What will be your process for choosing or developing such a tool?
  - Who will be involved in choosing or developing it?
  - How comprehensive will it be (what types of service will it be designed to encompass)?
- What "off the shelf" IIS product are you using or considering?
- What functions will/does your IIS serve? (See table 10)

Table 10: Worksheet on integrated information systems

	Have now	Plan to add	Is or will be web-based
Consumer education and information			
Provider tracking			
Client tracking			
Enrollment/disenrollment information			
Assessment and re-assessment.			
Census/socio-demographic information on client			
Eligibility data			
Utilization data			
Medical record			
Physician order entry system			
Medical care reviews			
Service authorization			
Appointments			
Prescription refills			
Unusual incident tracking			
Complaint and Grievance tracking			
Managerial cost/expense tracking			
Personnel data			
Marketing data			
Financial data			
Outcomes tracking			
Quality assurance			
Other:			
Other:			
Other:			